

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 91 years
 Hospital, institution, or street address where death occurred:
Washington County Home
 How long in hospital or institution? 1 yr. 8 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wash. Co., Home
 (If rural, give LOCATION)
 2.(c) If veteran, name war.....

3. (a) FULL NAME

Frederick Albert

3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	
6. (b) Name of husband or wife.....			
7. Birth date of deceased (mo., day, yr.) <u>July 10, 1854</u>			
8. AGE:	Years <u>91</u>	Months <u>9</u>	Days <u>12</u>hrs.min.
9. Birthplace <u>Wash. Co., Md.</u> (Town, county, and state)			
10. Usual occupation <u>Retired Butcher</u>			
11. Industry or business.....			
FATHER	12. Name <u>Albert</u>		
	13. Birthplace <u>Md.</u>		
MOTHER	14. Maiden name <u>Louise</u>		
	15. Birthplace <u>Md.</u>		
16. Informant <u>Mr. Charles D. Hammaker</u> Address <u>860 1/2 Virginia Ave. - Hagerstown,</u>			
17. <u>Burial</u> Date thereof <u>Apr. 24, 46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <u>Rose Hill Cemetery</u> Cemetery or crematory <u>Hagerstown, Md.</u> Location <u>Fred W. Kraiss</u> 18. Funeral director Address <u>Hagerstown, Md.</u>			
19. <u>Apr. 27, 46</u> <u>Chas. H. Powers</u> (Date rec'd by registrar) Registrar			

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 22, 1946 4:40 at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 46 to Apr. 22, 46 and that I last saw him alive on Apr. 22, 46

Immediate cause of death..... DURATION

Erysipelas (Facial) 4 days

Due to.....

Acute hemorrhagic nephritis. 2 days

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE Ernest F. Poremba M. D. or other
 Address Hagerstown Md Date signed 4/25/46

RECEIVED

APR 30 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04111

Reg. Dist. No. 302

1. PLACE OF DEATH

County Washington
City or town Marylandville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Washington
City or town Marylandville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

ABRAM H. BAER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Amanda Baer

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1879

8. AGE: Years 66 Months 8 Days 6 If less than one day
hrs. min.

9. Birthplace Washington Co md
(Town, county, and state)

10. Usual occupation Tanner

11. Industry or business Retired

12. Name Henry Baer

13. Birthplace Leicester Co. Pa

14. Maiden name Susana Harst

15. Birthplace Franklin Co. Pa

16. Informant Alney Baer

Address Marylandville md

17. B Date thereof April 17/46
(Burial, cremation, or removal. Whole (month) (day) (year))

Cemetery or crematory Paradise

Location Washington Co md

18. Funeral director R.E. Munnich

Address Greencastle Pa

19. April 15, 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1946 at 8⁴⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/3/43 to April 13 1946

and that I last saw him alive on April 13, 1946

Immediate cause of death
Carcinoma of rectum
Carcinoma of liver

DURATION
3 yrs
1 yr

Due to

Due to

Other conditions Intestinal obstruction 3 days

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of rectum with gland extension

Date of op. 1943 in Balt

Autopsy results none By Dr. Harvey Stone

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Blueisley MD M. D. or other
Address 148 W. Washington St. Date signed 4/15/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr

Kinsley

RECEIVED
APR 17 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460 ✓

CERTIFICATE OF DEATH

04112

14

Reg. Dist. No. 304

1. PLACE OF DEATH:

County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hancock,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Harry Balserr

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 15 1866
 8. AGE: Years 80 Months 0 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Russia
 (Town, county, and state)
 10. Usual occupation Lumber Dealer
 11. Industry or business _____

12. Name Not Known
 13. Birthplace ;; ;;
 14. Maiden name Not Known
 15. Birthplace Not Known
 16. Informant Bermand Conn
 Address Hancock, Md.

17. Burial Date thereof April 19 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore Hebrew Cemetery
 Location Baltimore, Md.

18. Funeral director Snyder, Rowland
 Address Hancock Md.

19. 4/18/46 J. A. Steller
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/17/46 19____ at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/44 19____ to 4/17/46 19____and that last saw him alive on 4/16/46 19____Immediate cause of death metastatic generalized carcinoma of pylorusDURATION about 2 1/2

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE H. Steller, M.D. M. D. or other _____Address Hancock Md. Date signed 4/17/46

RECEIVED

APR 26 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04113



Reg. Dist. No. 302

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph Barzella Barkdoll

3. (b) Social Security Number

220-05-6164

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... hrs..... min.....

9. Birthplace.....
 (Town, county, and state)
 10. Usual occupation.....

11. Industry or business.....
 12. Name.....
 13. Birthplace.....

14. Maiden name.....
 15. Birthplace.....

16. Informant.....
 Address.....

17. Burial.....
 (Burial, cremation, or removal. Which?).....
 Date thereof.....
 (month) (day) (year)
 Cemetery or crematory.....
 Location.....

18. Funeral director.....
 Address.....

19. (Date rec'd by registrar).....
 Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 18, 1946, at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 1946, to April 18, 1946, and that I last saw him alive on April 17, 1946.

Immediate cause of death.....
 DURATION.....

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....
 M. D. or other.....
 Address..... Date signed.....

RECEIVED

APR 23 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on FILM No. I O 4 MAY 13 1946 is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age **MARYLAND STATE DEPARTMENT OF HEALTH**
 of deceased is shown on
FILM No. I O 4 MAY 13 1946

2411 N. Charles St., Baltimore 98-2

CERTIFICATE OF DEATH

04114

Reg. Dist. No. 303

1. PLACE OF DEATH:

County..... Washington
 City or town..... Rural Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
Life
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Hagerstown Route
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland. County..... Washington
 City or town..... Rural Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Amand M. Betts

3.(b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Jacob F. Betts

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... June 5, 1856

8. AGE: Years..... 88 - 89 Months..... 10 Days..... 19 If less than one day..... hrs. min.

9. Birthplace..... Fiddlersburg, Maryland.
 (Town, county, and state)

10. Usual occupation..... Home Duties

11. Industry or business

----- Howard

12. Name..... Unknown

13. Birthplace..... Sarah -----

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... Jonas Betts

Address..... Hagerstown, Md. R. D.

17. Burial..... April 26, 1946
 (Burial, cremation, or removal. Which?)..... (month) (day) (Year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Maryland.

18. Funeral director..... Fred W. Kraiss

Address..... Hagerstown, Maryland.

18. April 26, 1946 Chas. H. Bowers
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

April 24, 1946 2:45 A.

20. DATE OF DEATH..... 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Chronic myocarditis 7 yrs
Chronic arthritis 12 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Autopsy results..... None Date of op.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... R. B. B. DEPUTY MEDICAL EXAM.
Hagerstown, Md. WASH. CO., MD.
 Address..... M. D. 4/26/46
 Date signed.....

RECEIVED
APR 29 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 980

CERTIFICATE OF DEATH

04115

Reg. Dist. No.

801

1. PLACE OF DEATH:

County Washington CountyCity or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 83 yrsHospital, institution, or street address where death occurred:
205 S. Conococheague St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 205 S. Conococheague St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. George Copenhaven Bowser

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Annie Long Bowser
deceased 6. (c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) July 22 18628. AGE: Years 83 Months 8 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Williamsport, Md.
(Town, county, and state)10. Usual occupation Finisher at Tannery11. Industry or business Byrons tannery WilliamsportFATHER 12. Name Jonathan Bowser
13. Birthplace MarylandMOTHER 14. Maiden name Dorothea J Hartman
15. Birthplace Maryland16. Informant Mr. J. Henson Bowser
Address 205 S. Conococheague St
Williamsport, Md.17. Burial (Burial, cremation, or removal. Which?) April 15 1946
(month) (day) (year)Cemetery or crematory Riverview Cemetery
Williamsport, Md.
Location _____18. Funeral director Edith V. Leaf
Address #7 Church St. Williamsport, Md.19. April 18 1946 Mr E L McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 46 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 19 46 to April 13 19 46 and that I last saw him alive on April 13 19 46

Immediate cause of death _____

DURATION

Probable Cardiac failure Instant

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John P. Zimmerman M. D. or other _____Address Williamsport Md. Date signed 4/14/46

RECEIVED

APR 17 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-2)

CERTIFICATE OF DEATH

Dr. Beachley

04116

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 11 Hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 11 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 317 Elizabeth St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3.(a) FULL NAME

Terry Wayne Burger

3.(b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife..... --
 6.(c) If alive, give age..... -- years
 7. Birth date of deceased (mo., day, yr.)..... March 3 1946
 8. AGE: Years..... 1 Months..... 1 Days..... 1 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation..... Infant

11. Industry or business

-

12. Name..... Frederick A. Burger

13. Birthplace..... Hagerstown Md.

14. Maiden name..... Cleo L. Snodderly

15. Birthplace..... Hagerstown Md.

16. Informant..... Frederick A. Burger

Address..... Hagerstown Md.

17. Burial Date thereof..... 4/4/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown Md.

18. Funeral director..... Andrew K. Coffman

Address..... Hagerstown Md.

19. April 3 19 46 Blanch Howard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 2 1946 19..... at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1946 to April 2 1946 and that I last saw him alive on April 2 1946

Immediate cause of death..... General Sept. Calmia DURATION

Due to.....

Due to.....

Other conditions..... Congenital Hydrocephalus
Cystic Degeneration
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Dr. Beachley M. D. or other
 Address..... Hagerstown Md. Date signed.....

RECEIVED

APR 5 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04117

Reg. Dist. No. 316

1. PLACE OF DEATH:

County WashingtonCity or town Rural-Keedysville
(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wash.City or town Rural-Keedysville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Catherine M. Dean

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife XX James E. Dean

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 11, 18948. AGE: Years 51 Months 8 Days 17 If less than one day _____ hrs. _____ min.9. Birthplace Clyphant--Lackawanna--Penna
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

12. Name George Hartman13. Birthplace Germany14. Maiden name Unknown15. Birthplace "16. Informant James E. DeanAddress Keedysville, Md. R. F. D.17. Burial Burial Date thereof May 2, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. PatrickLocation Clyphant, Penna18. Funeral director R. I. EarnshawAddress Keedysville, Md.19. May 14, 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1946 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 28, 1946 to April 28, 1946and that I last saw him alive on April 28, 1946Immediate cause of death Coronary Thrombosis

DURATION

24 hours

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hubert Wade M.D. M. D. or otherAddress Baltimore Md. Date signed 4/29/46

RECEIVED
MAY 3 1948
BUREAU V.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

CERTIFICATE OF DEATH

Dr. Ditto
04118

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington

City or town... Maugansville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

Mennonite Home

How long in hospital or institution? 20 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town... Maugansville
(If outside city or town limits, write RURAL and give nearest town)Street No. Mennonite Home
(If rural, give LOCATION)

2. (a) If veteran, name war No

3. (a) FULL NAME

Mrs. Lizzie Eshelman

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

8. (b) Name of husband or wife Peter E. (Deceased)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 5, 1859

8. AGE: Years Months Days If less than one day
87 2 19 hrs. min.9. Birthplace Maugansville, Wash. Cty., Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Michael H. Martin

13. Birthplace Lancaster, Pa.

14. Maiden name Pauline Hege

15. Birthplace Lancaster, Pa.

16. Informant Edgar Weber

Address Smithsburg, Md. R # 2

17. Burial Date thereof Apr. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Miller's Mennonite Cem.

Location Near Leitersburg, Md.

18. Funeral director A. E. Minnich

Address Greencastle, Pa.

19. April 25 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/24/46 19 to 4/24/46 19
and that I last saw him alive on 4/23/46 19

Immediate cause of death

Cerebral

Due to

Due to cerebral myelodysplasia
arterial sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Registrar Date signed April 26 46

RECEIVED
APR 27 1946
BUREAU V. E.

APR 27 1946

PAG. CONTENT

257

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31)

CERTIFICATE OF DEATH

★ 04119803
Reg. Dist. No.

1. PLACE OF DEATH

County Washington
 City or town Clear Spring Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3.5 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Clear Spring Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Isaac Forsyth

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 B.(b) Name of husband or wife Mary Forsyth
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 4 - 1858
 8. AGE: Years 88 Months 0 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business

12. Name Abraham Forsyth
 13. Birthplace Washington Co
 14. Maiden name Mary Bottles
 15. Birthplace Washington Co

16. Informant Lewis Forsyth
 Address Clear Spring
Rural
 Date thereof April 27 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Pauls Cemetery
 Location Near Clear Spring
 18. Funeral director Snyder Rowland
 Address Clear Spring Md

19. Date rec'd by registrar April 27 1946 Registrar Joseph W. Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946 at 11:25 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15, 1946 to April 24, 1946
 and that I last saw him alive on April 22, 1946
 Immediate cause of death Chr. Myocarditis DURATION 3 yrs.
Chr. Rhinitis 3 yrs.
 Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work?

23. SIGNATURE David R. Brewer M.D. M. D. or other
 Address Clear Spring Md Date signed 4/26/46

MARGIN RESERVED FOR BINDING

VS A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1946
BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

04120

Reg. Dist. No. 311

1. PLACE OF DEATH:

County WashingtonCity or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war

3. (a) FULL NAME

William Corsey Geeting

3. (b) Social Security Number

220-07-1180

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mrs. Ada Geeting6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) Sept. 3, 1870

8. AGE:

75Months 7Days 3

If less than one day

 hrs. min.9. Birthplace Keedysville-Wash.-Maryland
(Town, county, and state)10. Usual occupation President of11. Industry or business Keedysville Milling Co.12. Name Emanuel E. Geeting13. Birthplace Keedysville, Md.14. Maiden name Malinda Rohrer15. Birthplace Keedysville, Md.16. Informant Mr. Russell GeetingAddress Keedysville, Md.17. Burial Date thereof 4-9-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fair-ViewLocation Keedysville, Md.18. Funeral director R. L. EarnshawAddress Keedysville, Md.19. Apr 9 1946 R. L. Geeting
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 46 at 6:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6 19 46 to April 6 19 46and that I last saw him alive on April 6 19 46Immediate cause of death Cerebral Hemorrhage

DURATION

3 hoursDue to Arterial Hypertension5 yearsDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Robert Wade, Jr., M.D.

M. D. or other

Address Baltimore, Md. Date signed 4/7/46

RECEIVED
APR 11 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

Dr. Wells

04121

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Years
 Hospital, institution, or street address where death occurred:
613 North Mulberry St.
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 613 North Mulberry
 (If rural, give LOCATION)
 2. (a) If veteran, name war No

3. (a) FULL NAME

Charles Frederick Gelwicks

3. (b) Social Security Number

314-09-0627

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Nettie
 8. (c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) July 1 1881
 8. AGE: Years 64 Months 9 Days 7 If less than one day hrs. min.

9. Birthplace Hagerstown, Washington Co. Md.
 (Town, county, and state)
 10. Usual occupation Decorator
 11. Industry or business Porter Chemical Co.
 12. Name Frederick Gelwicks
 13. Birthplace Hagerstown, Maryland
 14. Maiden name Margarat Rumberger
 15. Birthplace Hagerstown, Maryland
 16. Informant Mrs. Harry May
 Address Hagerstown, Maryland

17. Burial Date thereof April 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director Andrew K. Coffman
 Address Hagerstown, Maryland.

19. April 9 19 46 Blair H. Boward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 19 46 at 5 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 19 46 to April 8 19 46
 and that I last saw and live on Apr 8, 19 46
 Immediate cause of death Cerebral embolus

DURATION

Due to Cerebral embolus 12 hrs.
 Due to Chr. myocarditis 6 yrs.
 Due to angina pectoris 3 yrs.
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide No Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE S. R. Hunt / Wells, M.D.
 Address Hagerstown, Md. Date signed 4/7/46

RECEIVED

APR 11 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04122

16

Reg. Dist. No. 304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
East Main StreetHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. East Main Street
(If rural, give LOCATION)2. (a) If veteran, name war -

3. (a) FULL NAME

Mary A. Siler Gilleece

3. (b) Social Security Number

-4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Thomas P. Gilleece7. Birth date of deceased (mo., day, yr.) May 23, 18706. (c) If alive, give age - years8. AGE: Years 75 Months 10 Days 30 If less than one day - hrs. - min.9. Birthplace Hancock, Washington Co., Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business -12. Name John Siler13. Birthplace Hancock, Md.14. Maiden name Elizabeth Anthony15. Birthplace Hancock, Md.16. Informant Thomas A. GilleeceAddress Moller Apts. Hagerstown, Md.17. Burial Date thereof April 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter's Catholic Church Cem.Location Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 4/23-46 John Siler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1946, at 12:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 15 1946 to Apr 22 1946 and that I last saw him alive on Apr 22 1946.Immediate cause of death Cerebral Hemorrhage

DURATION

Due to Arterio-sclerosisDue to -Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following

Accident, suicide, or homicide. Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE A. M. Shaffer MD

M. D. or other

Address Hancock Md Date signed 4/23/46

RECEIVED

APR 25 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

★ 04123 302
Reg. Dist. No.

1. PLACE OF DEATH:

County... Washington
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Washington Co HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pa County... FranklinCity or town... Greencastle
(If outside city or town limits, write RURAL and give nearest town)Street No. W. Franklin St
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

URILLA C. GOETZ

3. (b) Social Security Number

4. Sex 7 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Geo Goetz7. Birth date of deceased (mo., day, yr.) June 7, 1882 8. (c) If alive, give age 68 years8. AGE: Years 63 Months 10 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace Burnt Catons Pa
(Town, county, and state)10. Usual occupation Home Wife11. Industry or business Home12. Name... Thomas me Kelley13. Birthplace Penna14. Maiden name... Aliea Hicks15. Birthplace Pa16. Informant Geo GoetzAddress Greencastle Pa17. B Date thereof April 22/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery Cedar HillLocation Greencastle18. Funeral director P. E. MinnichAddress Greencastle Pa19. April 20, 1946 Geo H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 19 19 46, at 3 10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

9/1 19 39 to 4/19 19 46and that I last saw her alive on 4/19/46 19 46Immediate cause of death Cerebral hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE McBrew M. D. as aboveAddress Greencastle Pa Date signed 4/20/46

RECEIVED
APR 23 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 04124 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 months
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War II

3. (a) FULL NAME

Clarence Franklin Griffith

3. (b) Social Security Number

216-14-5893

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
B. (b) Name of husband or wife <u>Blanche (Abbott) Griffith</u>			
7. Birth date of deceased (mo., day, yr.) <u>Feb. 26, 1911</u>			
8. AGE:	Years <u>35</u>	Months <u>2</u>	Days <u>0</u>
If less than one dayhrs.min.			
9. Birthplace <u>Keedysville-Wash. - Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Truck-driver</u>			
11. Industry or business <u>Bester-Long</u>			
FATHER	12. Name <u>Raleigh Griffith</u>		
	13. Birthplace <u>Keedysville, Md</u>		
	14. Maiden name <u>Mary E. Myers</u>		
MOTHER	15. Birthplace <u>Boonsboro, Md</u>		
16. Informant <u>Mrs. Raleigh Griffith</u> Address <u>Keedysville, Md. R.F.D. #1</u>			
17. Burial <u>Burial</u> Date thereof <u>4-29-1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>National</u> Location <u>Sharpsburg, Md</u> <u>R. I. Earnshaw</u>			
18. Funeral director <u>R. I. Earnshaw</u> Address <u>Keedysville, Md</u>			
19. <u>April 27</u> 19 <u>46</u> <u>Chas. Powers</u> (Date rec'd by registrar) Registrar			

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 46 at 12:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/3 to 4/26 and that I last saw him alive on 4/25.

Immediate cause of death Brucella pneumoniae aculi alveolaris DURATION 2 days (3)

Due to ✓

Due to ✓

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide ✓ Date of 4/27/46
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Victor D. Miller
DR. VICTOR D. MILLER M. D. or other
 Address 111 W. WASHINGTON ST. Date signed 4/27/46

391M

UNITED STATES DEPARTMENT OF THE INTERIOR

WILSON STATION

UNITED STATES DEPARTMENT OF THE INTERIOR

UNITED STATES DEPARTMENT OF THE INTERIOR

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APR 30 1946
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UNITED STATES DEPARTMENT OF THE INTERIOR

WILSON STATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

CERTIFICATE OF DEATH

Dr. Ditto

04125

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) —

State..... Maryland County..... Washington
 City or town..... Maugansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3.(a) FULL NAME

Henry Hege

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower6.(b) Name of husband or wife..... Fannie

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 1 18648. AGE: Years Months Days If less than one day
82 2 7hrs.min.9. Birthplace..... Marion, Franklin Co. Pa.
(Town, county, and state)10. Usual occupation..... Farmer11. Industry or business..... Retired12. Name..... Henry Hege13. Birthplace..... Lancaster Pa.14. Maiden name..... Susan Leshner15. Birthplace..... Lancaster Pa.16. Informant..... Henry E. HegeAddress..... Maugansville Md.17. Burial Date thereof..... 4/11/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Reiffs Mennonite CemeteryLocation..... near Maugansville Md.18. Funeral director..... Andrew K. CoffmanAddress..... Hagerstown Md.19. April 9 1946..... Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 8 1946 19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-3-46 19..... to 4-8-46 19.....
and that I last saw him alive on 4-8-46 19.....

Immediate cause of death.....

DURATION

Branch Pneumonia2 days

Due to.....

Chas. Myerhoffs5 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

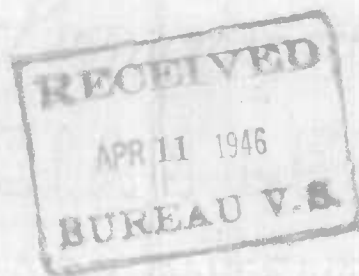
Means of Injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address..... Hagerstown Md. Date signed..... 4/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) X ✓

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County... WashingtonCity or town... Smithsburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... WashingtonCity or town... Smithsburg Md.
(If outside city or town limits, write RURAL and give nearest town)Street No... Water Street
(If rural, give LOCATION)

2(a) If veteran, name war...

3. (a) FULL NAME

Miss Emma Viola Holtzman

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 8 1895

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5086

.....hrs.

.....min.

9. Birthplace

Greensburg Md.
(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

FATHER

12. Name

E. J. Holtzman

13. Birthplace

Hagerstown Md.

14. Maiden name

Florence Stauffer

15. Birthplace

Chewsville Md.

16. Informant

Address

Joseph HoltzmanSmithsburg Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 26 1946
(month) (day) (year)

Cemetery or crematory

Smithsburg

Location

" Md.

18. Funeral director

Address

Walter G. Groves27 S. Church St. Waynesboro Pa

19.

(Date rec'd by registrar)

April 261946G. W. Ferguson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 24 19 46 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 19 45 to Apr. 24 19 46and that I last saw 4 alive on Apr. 23 19 46

Immediate cause of death

DURATION

Carcinoma of Breast 12 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Waynesboro Pa Date signed 4/24/46

RECEIVED
MAY 5 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 972

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Belts
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... Life

Hospital, institution, or street address where death occurred:

Hagerstown RD #4

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... WashingtonCity or town... Belts
(If outside city or town limits, write RURAL and give nearest town)Street No... Hagerstown RD #4
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

MARY W. HORST

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband or wife David H. Horst

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1863

8. AGE: Years Months Days If less than one day

83 1 19 hrs. min.

9. Birthplace

Belts md
(Town, county, and state)

10. Usual occupation

House Keeper

11. Industry or business

Home

12. Name

Jonas Eschleman

13. Birthplace

Laurens Co Pa

14. Maiden name

Wieser

15. Birthplace

Penna

16. Informant

Samuel E HorstAddress Hagerstown RD 417. (Burial, cremation, or removal, Which?) Date thereof Apr 5/46Cemetery or place of interment BeltsLocation near Maysville md

18. Funeral director

R.E. MinnichAddress Greencastle Pa19. (Date rec'd by registrar) Apr. 3, 1946Registrar Charles H. Howard

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946 at 4²⁰ A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 26 - 46 19, to Apr 5 - 46 19and that I last saw her alive on Apr 2 - 46 19

Immediate cause of death

Chr. Myocarditis

DUE TO

Chr. Myocarditis

DUE TO

Chr. Myocarditis

Other conditions

arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. C. [Signature]Date signed 7/9/46

CERTIFICATE OF DEATH

1-120
220
7-820

RECEIVED
APR 5 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *931*

CERTIFICATE OF DEATH

04128

Reg. Dist. No. *302*

1. PLACE OF DEATH: **Washington**
 County *Washington*
 City or town *Hagerstown, Maryland*
 (If outside city or town limits, write RURAL and give nearest town)
40 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Washington County Hospital
2 weeks
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Washington*
 City or town *Hagerstown*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *108 North Potomac Street*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Catherine M. Houck

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Widow**
 6.(b) Name of husband or wife **John L. Houck**
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) **September 22, 1866**
 8. AGE: Years **79** Months **6** Days **25** If less than one day _____ hrs. _____ min.

9. Birthplace **Millstone, Maryland**
 (Town, county, and state)
 10. Usual occupation **Housework**
 11. Industry or business
 12. Name **William Moffett**
 13. Birthplace **Clearspring, Maryland**
 14. Maiden name **Mary Dick**
 15. Birthplace **Clearspring, Maryland**
 16. Informant **Mrs. Charles Deininger**
 Address **Philadelphia, Pa.**

17. **Burial** Date thereof **4-18-46**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Episcopal Cemetery**
 Location **Hancock, Maryland**
 18. Funeral director **C. M. Suter & Sons**
 Address **Hagerstown, Maryland**

19. *April 17 46* *W. H. Bowers*
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: *April 15 46* *4 P.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1 - 46 19. *April 15 46*and that I last saw *him* alive on *April 13 46*

Immediate cause of death

DURATION

*Chr. Myocarditis**6 yrs*

Due to

*myocarditis**6 yrs*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address *W. H. Bowers* Date signed *4/18/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 20 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 110 West Washington Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Otho H. W. Hunter

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 8. (b) Name of husband or wife Betty Barber Bruin
 8. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) October 31, 1870
 8. AGE: Years 75 Months 5 Days 11 If less than one day hrs. min.

9. Birthplace Berkeley Springs, W.Va.
 (Town, county, and state)
 10. Usual occupation Retired Telephone Manager
 11. Industry or business

12. Name John Hunter
 13. Birthplace Martinsburg, W.Va.
 14. Maiden name Sophia Summers
 15. Birthplace Rockville, Maryland

16. Informant Anna Barber Bruin
 Address Hagerstown, Maryland

17. Burial Date thereof 4-13-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. April 12, 1946 Bea H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 April 19 46 at 1:52 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 April 19 46 to 11 April 19 46
 and that I last saw him/her alive on 10 April 19 46

Immediate cause of death Pneumonia, bronchial, diffuse DURATION 1 day

Due to.....
 Due to.....

Other conditions Influenza 5 days
Subacute pneumonia, healed
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE W. D. Layman, M.D.
 Address 100 Professional Auto Reg. M. D. or other 12 April 46
Hagerstown, Md. Date signed

APR 15 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 721

CERTIFICATE OF DEATH

Dr. Lusby

Reg. Dist. No. 041302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 Years

Hospital, institution, or street address where death occurred:

453 Mineral Ave

How long in hospital or institution?

None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 453 Mineral Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3.(a) FULL NAME

Albert Jenkins

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Emma6.(c) If alive, give age 81 years

7. Birth date of

deceased (mo., day, yr.)

April 28 1863

8. AGE:

Years

Months

Days

If less than one day

821117

hrs.

min.

9. Birthplace Edinburg Warren Co. Va.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Retired

FATHER

12. Name

Gabriel Jenkins

13. Birthplace

Edinburg Va.

MOTHER

14. Maiden name

Becky F. Williamson

15. Birthplace

Edinburg Va.

16. Informant

Norman F. Jenkins

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/30/46

(month) (day) (year)

Cemetery or crematory

Edge Hill Cemetery

Location

Charles Town W. Va.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

April 30 46

(Date rec'd by registrar)

Chas. Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 1946 19... at... 3 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

26 Apr19... 46to 28 Apr19... 46

and that I last saw him

alive on

26 Apr19... 46

Immediate cause of death

arterio sclerotic cardiac vascular disease

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. F. Lusby

M. D. or other

Address

230 N. PotomacDate signed 29 Apr 46

RECEIVED

MAY 2 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 36d

CERTIFICATE OF DEATH

 04131
 Reg. Dist. No. 302

1. PLACE OF DEATH: *Washington*
 County *Hagerstown*
 City or town *Hagerstown*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *20 yrs.*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Washington*
 City or town *Hagerstown*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *W. North Street*
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME *Rosie Kane*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *Negro* 6. (a) Single, married, widowed, or divorced *Single*
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) *January 17, 1909* 6. (c) If alive, give age _____ years
 8. AGE: Years *37* Months *3* Days *3* If less than one day _____ hrs. _____ min.

9. Birthplace *Williamsport - Wash. Ind.*
 (Town, county, and state)
 10. Usual occupation *Roadster*

11. Industry or business
 12. Name *Tharnton Kane*
 13. Birthplace *Williamsport, Ind.*
 14. Maiden name *Beaulah Hamilton*
 15. Birthplace *Williamsport, Ind.*

16. Informant *Catharine Kane*
 Address *428 Sumner Alley*
 17. *Burial* Date thereof *4/24/46*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Rose Hill Cemetery*
 Location *Hagerstown, Ind.*

18. Funeral director *Wm. H. Downey*
 Address *291 Frederick Street*
 19. *April 24, 46* *Wm. H. Downey*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 20, 1946* at *9:50 P.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death *Syphilitic aortitis*
Partial coronary occlusion

Due to _____

Due to _____

Other conditions _____

(include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy result *As above*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

DEPUTY MEDICAL EXAM.

23. SIGNATURE *J. Robert Wells* WASH. CO., MD.
 M. D. _____

Address *Hagerstown, Ind.* Date signed *4/23/46*

RECEIVED
APR 26 1946
BUREAU V. S.

Dr. Wade

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04132

Reg. Dist. No. 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Washington
 City or town Marysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Main St.
 How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Marysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Main St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Edith Catharine Kaylor

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January - 26 - 1871
 8. AGE: Years 75 Months 2 Days 11 If less than one day _____ hrs. _____ min.
 9. Birthplace Washington County Md.
 (Town, county, and state)
 10. Usual occupation None

11. Industry or business

MOTHER FATHER
 12. Name Cyrus B. Kaylor
 13. Birthplace Washington County Md.
 14. Maiden name Catherine Conrad
 15. Birthplace Washington County Md.
 16. Informant Omer J. Kaylor Brice Bldg.
 Address Hagerstown Md.

17. Burial Date thereof April 10, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Church of the Brethren Cemetery
Beaver Creek Md.
 Location Wm J. Bast & Sons
 18. Funeral director Brownson Md.
 Address John W. Bast
 19. April 10, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April - 7th 1946, at 9⁴⁵ P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 3rd 1944, to April 7th 1946,
 and that I last saw her alive on April 7th 1946.

Immediate cause of death

Arteriosclerosis of heart

DURATION

1 yr. 9 mo. 4 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE John W. Bast M. D. or otherAddress Brownson Md. Date signed 4/8/46

RECEIVED
APR 12 1946
MILITARY & R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-3

CERTIFICATE OF DEATH

04133

Reg. Dist. No. 362

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County City or town Unknown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2(a) If veteran, name war

3. (a) FULL NAME

William J. Kearns

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u> </u>
-----------------------	----------------------------------	---

6. (b) Name of husband or wife 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
<u>About 70</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u> </u> hrs. <u> </u> min.

9. Birthplace Unknown
(Town, county, and state)10. Usual occupation 11. Industry or business 12. Name Unknown13. Birthplace 14. Maiden name Unknown15. Birthplace 16. Informant Dr. S. R. WellsAddress Hagerstown, Md.17. Burial Date thereof Apr. 23-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bellevue CemeteryLocation Wash. Co. Home- Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. April 23 46 Black Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 19 46, at 8:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

 19 , to 19 and that I last saw alive on 19 Immediate cause of death

DURATION

Multiple fracturesShockDue to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/20/46Where did injury occur? East of Punkstown Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway Route #40Means of injury Struck by auto Injured at work? No23. SIGNATURE A. Robert Wells WASH. CO., MD.Address Hagerstown, Md. Date signed 4/23/46

RECEIVED
APR 25 1946
BUREAU V. E.

This man was a transient and unknown in this City. The Police Dept. were unable to obtain any further information for the Death Certificate.

F. W. Kraiss .
(an auditor)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Rural Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington
 City or town Rural Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

John Calvin Kline

3. (b) Social Security Number

no

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Orpha Kline6. (c) If alive, give age 71 years

7. Birth date of

deceased (mo., day, yr.)

March 8, 1868

8. AGE:

Years

Months

Days

If less than one day

78029

hrs.

min.

9. Birthplace

Boonsboro, Washington Co. Md.
(Town, county, and state)

10. Usual occupation

Salesman Retail

11. Industry or business

FATHER

12. Name

Henry Kline

13. Birthplace

Boonsboro, Md.

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

George W. Kline

Address

Boonsboro, Md.

17.

Burial

Date thereof

4-9-1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Lutheran Cemetery

Location

Boonsboro, Md.

18. Funeral director

Old Hill Co.

Address

Middletown, Md.

19.

April 8, 1946
(Date rec'd by registrar)

19 46

John H. Bask
Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 6, 1946at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1, 1946to April 6, 1946

and that I last saw him alive on

April 6, 1946

Immediate cause of death

Uremia

Due to

Hypertension

Due to

Arteriosclerosis

Other conditions

Dry gangrene of both legs

(Include pregnancy within 3 months of death)

DURATION

6 mon10 yrs.10 yrs.3 mon

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. Lister M.D.

M. D. or other

Address

Boonsboro

Date signed

4/8/46

RECEIVED
APR 12 1946
BUREAU 7 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

04135 302
Reg. Diat. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 73-9-9-
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution? 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington County Home
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Alfred Luther Knode

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Clara Knode57 years7. Birth date of deceased (mo., day, yr.) July 13, 1872

8. AGE:

73 Years9 Months9 Days

If less than one day

.....hrs.min.

9. Birthplace

Hagerstown Wash. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Grover Knode

FATHER

12. Name

Grover Knode

13. Birthplace

Hagersyown Md.

MOTHER

14. Maiden name

Alice Kendall

15. Birthplace

Hagerstown Md.

16. Informant

Mrs. Leda Knode Peters

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof April 24, 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown Md.

19.

April 23 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1946 at 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....
and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DURATION

C.R. myocarditis 10 yrs
Due to.....
coronary heart disease 5 yrs
Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

S. Robert Wells Resident Med Exam.
Hagerstown Md. 4/23/46
Address..... Date signed.....

RECEIVED
APR 25 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

CERTIFICATE OF DEATH

Reg. Dist. No. 04136 362

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred:
 Washington County Hospital

How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland Washington
 City or town... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1165 Hamilton Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy of Myer Linzner

3. (b) Social Security Number

None

4. Sex Male
 5. Color or race White
 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1946

8. AGE: Years Months Days If less than one day
 5 hrs. min.

9. Birthplace... Hagerstown, Washington co. Md.
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name... Myer Linzner

13. Birthplace... Philadelphia, Penna.

14. Maiden name... Jennett Michell

15. Birthplace... Philadelpha, Penna.

16. Informant... Myer Linzner

Address... Hagerstown, Maryland.

17. Burial Date thereof April 23-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Hebrew Cemetery

Location... Hagerstown, Maryland.

Fred W. Kraiss

18. Funeral director... Hagerstown, Maryland.

Address

19. April 23, 46 Beach Powers

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 20, 1946 2:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Premature (8mo)

(Cesarean delivery)

Partial atelectasis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of

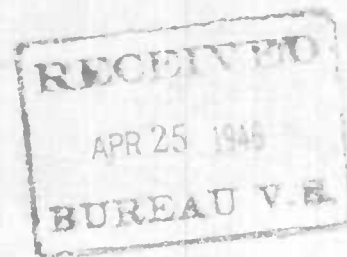
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. Robert Wells, M.D.

Address... Hagerstown, Md. Date signed 4/21/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04137

Reg. Dist. No.

300

1. PLACE OF DEATH:

County... Washington CountyCity or town... Sharpsburg Md. RFD #1
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 39 yrs

Hospital, institution, or street address where death occurred:

Sharpsburg Md. RFD #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Sharpsburg Md. RFD #1
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Bessie Virginia Lowery

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Single</u>

6.(b) Name of husband or wife... Single7. Birth date of deceased (mo., day, yr.) Feb. 21 18838. AGE: Years Months Days If less than one day
63 1 21hrs.min.9. Birthplace... Bakersville Dist. Md.
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... Home12. Name... Benjamin Lowery13. Birthplace... Washington Co. Md.14. Maiden name... Mary Hines15. Birthplace... Keedysville Dist Md.16. Informant... Roy Lowery (son)Address 118 W. Potomac St. Williamsport17. Burial Date thereof April 15 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Bakersville CemeteryLocation... Near Bakersville Maryland18. Funeral director... Edith V. LeafAddress #7 Church St. Williamsport, Md.19. 4-13 19. Apr 13 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946 at 11 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/4/46 19. 4/11/46 to 4/11/46 19. 4/11/46
and that I last saw him alive on 4/11/46 19. 4/11/46

Immediate cause of death

Consumption Stomach & The fastanis to liver & Reticles

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address Williamsport, Md Date signed 4/12/46

RECEIVED

MAY 5 1946

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

Dr. Norment

CERTIFICATE OF DEATH

Reg. Dist. No. 04120302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one year

Hospital, institution, or street address where death occurred:

none

How long in hospital or institution?

none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 29 N. Mulberry St.

(If rural, give LOCATION)

2. (a) If veteran, name war no

3. (a) FULL NAME

Clarence Luther Main

3. (b) Social Security Number

214-09-0359

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Mary C.6. (c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) October 9, 18768. AGE: Years Months Days If less than one day
69 6 14 hrs. min.9. Birthplace Westminister, Carroll Cty., Md.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Harry S. Myers12. Name Martin Luther MAIN13. Birthplace Middletown, Md.14. Maiden name Clay Ann Wagoner15. Birthplace Westminister, Md.16. Informant Mrs. Mary C. MainAddress Hagerstown, Md.17. Burial Date thereof April 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest HavenLocation Hagerstown, Md.18. Funeral director Andrew CoffmanAddress Hagerstown, Md.19. April 25 46 Black Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1946 at 3 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 to April 23and that I last saw him live on April 23

Immediate cause of death

DURATION

Coronary occlusion15 minutesDue to Coronary sclerosisyearsDue to Generalized arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work?23. SIGNATURE Dr. Norment M. D. or otherAddress Hagerstown, Md. Date signed April 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 27 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-6

CERTIFICATE OF DEATH

Dr. Kritzer

04139302
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 17 Years
 Hospital, institution, or street address where death occurred:
15 North Mulberry St.
 How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 15 North Mulberry Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No

3. (a) FULL NAME

Mrs Gertrude Moats Malley

3. (b) Social Security Number

219#20-0941

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widow
 8. (b) Name of husband or wife..... Samuel
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... April 5, 1892
 8. AGE: Years..... 53 Months..... 11 Days..... 28 If less than one day..... hrs. min.
 9. Birthplace..... Tilghmantown Washington Co., Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business..... Own Home

FATHER 12. Name..... Hiram Moats
 13. Birthplace..... Tilghmantown, Maryland
 MOTHER 14. Maiden name..... Little Kitzmiller
 15. Birthplace..... Fairplay, Md.
 16. Informant..... Miss Betty Malley
 Address..... Hagerstown, Maryland
 17. Burial..... Burial Date thereof..... April 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Manor Cemetery
 Location..... Near Tilghmantown, Maryland
 18. Funeral director..... Andrew K. Coffman
 Address..... Hagerstown, Maryland
 19. Apr. 8. 19 46 Charles Bower
 (Day rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3, 19 46, at..... 3P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3-8- 19 46 to 4-3- 19 46
 and that I last saw her alive on 4-3-46 19

Immediate cause of death..... DURATION

Toxycardia - Heart failure - 1 day
Influenza 2 wks -
 Due to.....
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Hagerstown Md Date signed 4/5/46

RECEIVED
APR 10 1946
BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 652

CERTIFICATE OF DEATH

Dr. Prather

04140

302

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 9 years

Hospital, institution, or street address where death occurred:

138 East Lee Street

How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Washington

City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 138 East Lee Street

(If rural, give LOCATION)

2(a) If veteran, name war..... No

3. (a) FULL NAME

Donald Frederick Marsee Sr.

3. (b) Social Security Number

215-05-3956

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... S. Eliz.

6. (c) If alive, give age..... 28 years

7. Birth date of deceased (mo., day, yr.)

Feb. 19, 1916

8. AGE:

Years

Months

Days

If less than one day

30

2

6

hrs.

min.

9. Birthplace..... Corbin Knox Cty., Ky.

(Town, county, and state)

10. Usual occupation..... Fire Man

11. Industry or business..... Western Md. Railway Co.

FATHER
MOTHER

12. Name..... James Luther Marsee

13. Birthplace..... Middlesboro, Ky.

14. Maiden name..... Rose Kellein

15. Birthplace..... Pineville, Ky.

18. Informant..... Mrs Donald Marsee

Address..... Hagerstown, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... April 28, 1946

(month) (day) (year)

Cemetery or crematory..... Rest Haven Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... Andrew K. Coffman

Address..... Hagerstown, Maryland

19. April 26, 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 25, 1946, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 24, 1946 to Apr. 25, 1946

and that I last saw him alive on April 25, 1946

Immediate cause of death.....

Cerebral disease

DURATION

3

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Physician: Adrenals invaded by multiple growths.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. Prather

Address..... Hagerstown, Md. Date signed..... 4/25/46

RECEIVED

APR 29 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Dr. Ditto

04141

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Months

Hospital, institution, or street address where death occurred:

2209 Virginia Ave.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 2209 Virginia Ave
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Lutie Hershry McDade

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

8. (b) Name of husband or wife

Harlan E.

7. Birth date of

deceased (mo., day, yr.)

May 11 1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

791026

..... hrs.

..... min.

9. Birthplace

Hopewell Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Joseph Hershey

13. Birthplace

Hagerston Md.

MOTHER

14. Maiden name

Margaret Speck

15. Birthplace

Welsh Run Pa.

18. Informant

Mrs. Grace Hoch

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/9/46

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

A. K. Calfman

Address

Hagerstown, Md.

19.

(Date rec'd by registrar)

19.

Chas. H. Bowers

Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH April 7 1946 19....., at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-15-46 19....., to 4-7-46 19.....and that I last saw him alive on 3-26-46 19.....

Immediate cause of death

DURATION

Coronary Disease3 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown Md. Date signed 4/9/46

RECEIVED
APR 11 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04142

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Mason And Dixon
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... WashingtonCity or town... Mason And Dixon
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

HENRY PRATHER McLAUGHLIN

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife... Anna Zellers
January 26, 1856

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
90 2 23 hrs. min.9. Birthplace... Washington Co., Md.
(Town, county, and state)10. Usual occupation... Merchant11. Industry or business... Grain, feed and Coal12. Name... Perry B. McLaughlin13. Birthplace... Maryland14. Maiden name... Cornelia Hostetter15. Birthplace... Maryland16. Informant... Mrs. Bertha LarrickAddress... Mason And Dixon, Md.17. Burial Date thereof... 4-23-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Salem ChurchLocation... Cearfoss, Md.18. Funeral director... Joseph A. DieterAddress... Greencastle, Pa.19. April 22, 46 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 4/19 19 46 at 1:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
4/12 19 46 to 4/19 19 46
and that I last saw him alive on 4/15 19 46

Immediate cause of death

Carcinoma of Pharynx

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... M. D. or other

Address... Greencastle, Pa. Date signed 4/21/46

RECEIVED

APR 24 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04143

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 41 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?..... 17 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Washington

City or town..... Rural Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Cedar Lawn

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

William L. Meyers

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Beulah Meyers

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 2, 1886

8. AGE:

Years
60Months
2Days
2

If less than one day

..... hrs. min.

9. Birthplace

Baltimore, Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

FATHER

12. Name

Abraham Meyers

MOTHER

13. Birthplace

Lithuania,

14. Maiden name

Lena Klavansky

15. Birthplace

Lithuania

16. Informant

Mrs. William Meyers

Address

Cedar Lawn Hagerstown, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

April 7, 1946

(month) (day) (year)

Cemetery or crematory

Hebrew Cemetery

Location

Hagerstown, Md.

18. Funeral director

F. W. Kraiss

Address

Hagerstown, Md.

19.

Apr 7, 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 5, 1946..... 3:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 10, 1946 to April 5, 1946

and that I last saw him alive on April 4, 1946

Immediate cause of death

Carcinoma of descending Colon About
with metastases to Liver.

DURATION

8 mos.

Due to.....

Due to.....

Other conditions

None.

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma Colon & Liver.

Autopsy results

No autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Hagerstown, Maryland Date signed..... 4-5-46

RECEIVED
APR 9 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 44 Years
 Hospital, institution, or street address where death occurred:
845 Chestnut St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 845 Chestnut St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3.(a) FULL NAME
Mary C. Miller

3.(b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife... George L. Miller
 6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) Nov. 5, 1896
 8. AGE: Years 49 Months 5 Days 22 If less than one day
hrs.min.

9. Birthplace Jefferson County, W. Va.
 (Town, county, and state)
 10. Usual occupation... Home Duties
 11. Industry or business

FATHER 12. Name Joseph Keller
 13. Birthplace Shepherdstown W. Va.

MOTHER 14. Maiden name Annie Kelley
 15. Birthplace Berkeley Co. W. Va.

16. Informant George L. Miller
 Address Hagerstown, Md.

17. Burial Date thereof April 29, 1946
 (Burial, cremation, or removal, which?) (month) (day) (year)
Rest Haven Cemetery
 Cemetery or crematory
 Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. Apr. 30, 46 Chas. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH April 26, 1946 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 26, 1946 to April 26, 1946
 and that I last saw him/her alive on April 26, 1946

Immediate cause of death.....
Cerebral Hemorrhage 5 hrs
Hemiplegia rt. 5 hrs.
 Due to.....
Hypertension 3 yrs.
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Ernest J. Poole M.D.
 M. D. or other
 Address Hagerstown Md Date signed 4/29/46

RECEIVED
MAY 2 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 812

CERTIFICATE OF DEATH

Dr. Wells

★ 04145 302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 1/2 Years
Hospital, institution, or street address where death occurred:
16 East Lincoln Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 East Lincoln Ave
(If rural, give LOCATION)
2(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Mary Elizabeth Moyers

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife Edward7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age — yearsDecember 22 1861

8. AGE: Years Months Days If less than one day

84 3 11 hrs. min.9. Birthplace Brushy Run Pendleton Co. W. Va.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Edward Pretzel13. Birthplace Brushy Run W. Va.14. Maiden name Anna Wolford15. Birthplace Elkins W. Va.16. Informant Mrs. Addie ShawAddress Hagerstown Md.17. Burial Date thereof 4/5/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Sugar Grove CemeteryLocation Sugar Grove W. Va.18. Funeral director Andrew K. CoffmanAddress Hagerstown / Md.19. April 3 19 46 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1946 19... at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death DURATION

Arteriosclerosis 10yrsDue to acute cerebral hemorrhage 4hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM. WASH. CO., MD.23. SIGNATURE S. Robert Wells M. D.Address Hagerstown, Md. Date signed 4/3/46

RECEIVED

APR 5 1948

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04146

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County FrederickCity or town Middletown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Ellen Muck

3. (b) Social Security Number

no

4. Sex _____ 5. Color or race _____ 6. (a) Single, married, widowed, or divorced _____

Female white Married6. (b) Name of husband or wife David W. Muck7. Birth date of deceased (mo., day, yr.) June 13, 1867 6. (c) If alive, give age 78 years8. AGE: Years 78 Months 9 Days 28 If less than one day _____ hrs. _____ min.9. Birthplace Boonsboro, Washington Co., Md.
(Town, county, and state)10. Usual occupation House wife

11. Industry or business _____

12. Name Simon Lizer13. Birthplace Boonsboro, Md.14. Maiden name Mary Jane Fackler15. Birthplace Boonsboro, Md.16. Informant David W. MuckAddress Middletown, Md.17. Burial Date thereof 4-13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory U. B. CemeteryLocation Myersville, Md.18. Funeral director Chadhill Co.Address Middletown, Md.19. April 12 46 Gray/Howers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946 at 10:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 46 1946 to April 11 1946 and that I last saw him alive on April 10 1946

Immediate cause of death _____

Carcinoma of descending colon

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. W. Lizer M.D. M. D. or other _____Address Boonsboro Date signed 4/12/46

RECEIVED

APR 17 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04147302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 night
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 night

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Allie Bertha Booth Pittman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Ezra Pittman

7. Birth date of deceased (mo., day, yr.) March 3, 1868

8. AGE: Years 78 Months 1 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Warfordsburg, Fulton Co., Penna.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Booth
 13. Birthplace Warfordsburg, Penna.

14. Maiden name Maria Lynch15. Birthplace Warfordsburg, Penna.16. Informant Mrs. Andrew Bishop (niece)Address Hancock, Md.

17. Burial Date thereof Apr. 15, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Warfordsburg PresbyterianLocation Warfordsburg, Penna.16. Funeral director Charles R. BastAddress Hancock, Md.

19. Apr. 14, 1946 Registrar Charles Bowers
 (Date fee'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1946 at 6:37 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Malignancy of gall bladder
Cholelithiasis (gallstone)

Due to Hypostatic pneumonia

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Robert Wells Deputy Medical Examiner Wash. Co.
 M. D. number _____

Address Hagerstown, Md. Date signed Apr. 14/46

RECEIVED
APR 16 1948
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04148

27

1. PLACE OF DEATH:

County Washington
City or town Hyattsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution Washington Co. Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 hr.
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____
City or town _____ Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Baby Girl Poffinberger

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

April 18, 1946

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace Washington Co. Hospital

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name William Luther Poffinberger, Jr.

13. Birthplace Hyattsville, Md.

14. Maiden name Grace Adams Byers

15. Birthplace Philadelphia, Pa.

16. Informant Mrs. William L. Poffinberger, Jr.

Address 334 Summit Ave. Hyattsville, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof _____ (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Apr. 22, 1946 Phyllis Howard

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 18, 1946 at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____ to 19 _____

and that I last saw him on

19 _____

Immediate cause of death

Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. J. Layman, M.D.

Address

1000 Broadway Ave. N.W.

M. D. or other

Date signed

21 Apr 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 14141303

1. PLACE OF DEATH:

County... WASHINGTON
 City or town... RURAL HAGERSTOWN MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 12 YEARS
 Hospital, institution, or street address where death occurred:
(CEDAR LAWN)
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... WASHINGTON
 City or town... RURAL HAGERSTOWN MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... (CEDAR LAWN)
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

JACOB R. REID
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced WIDOWED

6.(b) Name of husband or wife... HELEN M.

8.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) JUNE 8 1857

8. AGE: Years 88 Months 9 Days 24 if less than one day
 hrs. min.

9. Birthplace... HAGERSTOWN WASH. MD.
(Town, county, and state)10. Usual occupation... FARMER (RETIRED)

11. Industry or business

12. Name... WILLIAM P REID13. Birthplace... HAGERSTOWN, MD.14. Maiden name... MARY A. SCHAMEL15. Birthplace... ST. JAMES, MD.16. Informant... FRANK J REIDAddress... HAGERSTOWN17. BURIAL Date thereof... Apr 4 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... MANOR CEMETERYLocation... TILGHMANTON MD18. Funeral director... C M SUTER & SONSAddress... HAGERSTOWN MD19. April 4 46 Phas Flowers
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH... Apr 2 19 46 at 6:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 19 46 to April 2 19 46and that I last saw him... alive on April 1 19 46Immediate cause of death... Cerebral hemorrhageDue to... Cerebral hemorrhageDue to... Cerebral hemorrhageOther conditions... Cerebral hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations... Cerebral hemorrhageDate of op. 2 yearsAutopsy results... Cerebral hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Phas FlowersAddress... Phas FlowersDate signed... 4/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96

CERTIFICATE OF DEATH

04150

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... **Washington**
 City or town..... **Hagerstown, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
Life
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... **6 weeks**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County..... **Washington**
 City or town..... **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **127 East Washington Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William H. Roe

3. (b) Social Security Number

214-16-0916

4. Sex..... **Male**
 5. Color or race..... **White**
 6.(a) Single, married, widowed, or divorced..... **Married**
 6.(b) Name of husband or wife..... **Vada Roe**
 6.(c) If alive, give age..... **25** years
 7. Birth date of deceased (mo., day, yr.)..... **March 14, 1922**
 8. AGE: Years..... **24** Months..... **0** Days..... **29**
 If less than one day..... hrs. min.

9. Birthplace..... **Hagerstown, Wash. Co. Md.**
 (Town, county, and state)
 10. Usual occupation..... **Inspector**
 11. Industry or business..... **Fairchild Air Craft**
 12. Name..... **William H. Roe, Sr.**
 13. Birthplace..... **Easton, Maryland**
 14. Maiden name..... **Addie Simmon**
 15. Birthplace..... **Crumpton, Maryland**
 16. Informant..... **Mrs. William H. Roe**
 Address..... **Hagerstown, Maryland**
 17. Burial..... Date thereof..... **4-15-46**
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... **Rose Hill Cemetery**
 Location..... **Hagerstown, Maryland**
 18. Funeral director..... **C. M. Suter & Sons**
 Address..... **Hagerstown, Maryland**
 19. **April 13 1946**..... **Chas. H. Gowers**
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 12th 1946** at **8:55 P.M.**
 21. I CERTIFY that death occurred on the date stated; that I attended deceased from **March 17th 1946** to **April 12th 1946**
 and that I last saw him alive on **April 12 1946**

Immediate cause of death.....
(1) Rupture of aorta
 Due to..... **Embolus**
(2) Cerebral Embolus
 Due to.....
 Other conditions..... **Rheumatic Fever**
Panocarditis Acute
 (Include pregnancy within 3 months of death)
 DURATION.....
3 days
2 wks
6 wks

Major findings of operations.....
 Autopsy results..... **Rupture of aorta, Cerebral embolus, Panocarditis**
 PHYSICIAN: Please underline the cause to which death should be charged statistically. **Heart**

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... **Chas. H. Gowers** M. D. or other.....
 Address..... **1594 W. Washington St** Date signed..... **4/13/46**

RECEIVED
APR 16 1948
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04151

Reg. Dist. No. 323

1. PLACE OF DEATH:

County Washington
 City or town Rural Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
Hagerstown Route 2
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Rural Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Route 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Alice V. Sellers

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Harry B Sellers
 7. Birth date of deceased (mo., day, yr.) January 25, 1871 8.(c) If alive, give age _____ years
 8. AGE: Years 75 Months 2 Days 15 It less than one day _____ hrs. _____ min.
 9. Birthplace Near Tighmanton Wash. Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None

FATHER 12. Name Poffenberger
 13. Birthplace Tighmanton Md.
 MOTHER 14. Maiden name Elizebeth Vernon
 15. Birthplace Tilghmanton Md.

16. Informant H. Clyde Ridenour
 Address Hagerstown Rt. 2

Burial April 12, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Near Clearspring Md.

18. Funeral director Scott F. Minnich & Son
 Address Hagerstown Md.

19. April 11 19 46 David G. Brewer Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 19 46 at 12:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 46 to April 10 19 46
 and that I last saw him alive on April 10 19 46

Immediate cause of death Coronary Thrombosis
Arterio Sclerosis
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

DURATION

Sudden

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David G. Brewer M.D. M. D. or other
Clear Spring Md. Address _____ Date signed 4/10/46

RECEIVED

MAY 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7-2

CERTIFICATE OF DEATH

Dr. Hornbaker

★ 14152 302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Rogers town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 mos.
 Hospital, institution, or street address where death occurred:
Hill Crest Convalescent Home
 How long in hospital or institution? 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County New York
 City or town New York City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 144 E. 45th St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

Mary S. Shields
 4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 22, 1857

8. AGE: Years 88 Months 10 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Florida, Orange Cty., N. Y.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own home

12. Name George William Seward

13. Birthplace Florida, N. Y.

14. Maiden name Julia F. Humphrey

15. Birthplace Newburgh, N. Y.

16. Informant Paul Shields

Address Rogers town, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Apr. 29, 1946
 (month) (day) (year)

Cemetery or crematory Oregreen Cemetery

Location Florida, N. Y.

18. Funeral director Andrew F. Coffman

Address Rogers town, Md.

19. April 26, 1946 Registrar Chas. H. Bowers

(Date rec'd by registrar)

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/12 1944, to 4/25 1946

and that I last saw h. ex alive on 4/25/46 1946

Immediate cause of death Bronchopneumonia

Due to hx DURATION 3 days

Due to _____

Other conditions hypertensive cardiovascular disease + generalized arteriosclerosis unknown

(Include pregnancy within 6 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John Hornbaker M.D.

Address 144 E. 45th St., New York City Date signed 4/26/46

M. D. or other

RECEIVED

APR 29 1946

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

04153

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs.
 Hospital, institution, or street address where death occurred:
417 Linganore Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 417 Linganore Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clara Rebecca Simmers

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Henry Simmers (Deceased)

7. Birth date of deceased (mo., day, yr.) May 12, 1863
 6.(c) If alive, give age years

8. AGE: Years 82 Months 10 Days 25 If less than one day
 hrs. min.

9. Birthplace Moorefield, W. Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Samuel Mongold13. Birthplace Moorefield, W. Va.14. Maiden name Ritnour15. Birthplace W. Va.16. Informant Angus L. ReedyAddress Hagerstown, Md.

17. Burial Date thereof Apr. 9, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director L. F. ReeherAddress Funkstown, Md.19. April 9 19 46 Chas H Bowerd

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1946 11:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 5, 1946 to April 7, 1946
 and that I last saw him/her alive on April 2, 1946

Immediate cause of death Chronic myocarditis with congestive failure
 DURATION Indef.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Bowerd M.D.Address 148 W. Washington St. Date signed 4/8/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04154

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, institution, or street address where death occurred:

712 George Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 George Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Nettie H. Sites

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Calvin E. Sites

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1863

8. AGE:

Years

83

Months

3

Days

If less than one day

hrs.

min.

9. Birthplace Chambersburg, Penna.

(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Henry Fennel13. Birthplace Franklin County, Penna.14. Maiden name Elizabeth Herning15. Birthplace Franklin County, Penna.16. Informant Russel K. SitesAddress 712 George St. Hagerstown, Md.17. Burial April 30, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Grove CemeteryLocation Chambersburg, Penna.

Fred. W. Kraiss

18. Funeral director Hagerstown, Maryland.

Address

19. April 30, 1946 Chas. H. Bowers

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

April 28, 1946 5:15A

20. DATE OF DEATH 19 46 21

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1946 to April 28, 1946and that I last saw him alive on April 26, 1946

Immediate cause of death

DURATION

arterio-sclerosis ?Due to chronic endocarditis ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death.)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller M. D. or otherAddress 131 W. WASHINGTON Date signed 4/29/1946

HAGERSTOWN, MD.

RECEIVED

MAY 2 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington CountyCity or town Spealman Station Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spealman Station Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Spealman Station Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Spealman Station Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Sarah Smith

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widowed</u>

6. (b) Name of husband or wife William Smith
deceased7. Birth date of deceased (mo., day, yr.) July 23 1853

8. AGE:	Years	Months	Days	If less than one day
<u>92</u>	<u>8</u>	<u>29</u>	<u>hrs.</u>	<u>min.</u>

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name John Moats13. Birthplace Frederick County14. Maiden name Annie Bloom Moats15. Birthplace Fairplay16. Informant Mrs. Annie MoatsAddress Spealman Station Maryland17. Burial Date thereof April 30 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Manor CemeteryLocation Near Tilghmanton Md.18. Funeral director Edith V. LeafAddress #7 Church St. Williamsport, Md.19. 4/30 19 46 Mrs E Lee McChoy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 46 at 11 15 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 46 to April 27 19 46 and that I last saw him alive on April 25 19 46Immediate cause of death Seriously ill
I know of no other cause

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Willington M. D. or otherAddress Willington Md. Date signed 4/30/46

RECEIVED

MAY 3 1946

BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

04156

Reg. Dist. No. 302

1. PLACE OF DEATH County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>68-7-28</u> Hospital, institution, or street address where death occurred: <u>Hillcrest Nurseling Home</u> How long in hospital or institution?..... <u>2 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>908 Mulberry Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Daniel Clyde Snyder</u>				3. (b) Social Security Number <u>214-09-9364</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>			
6. (b) Name of husband or wife <u>Mary E. Snyder</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>August 15, 1877</u>				8. AGE: Years <u>68</u> Months <u>7</u> Days <u>28</u> If less than one day..... hrs. min.			
9. Birthplace <u>Hagerstown Wash. Md.</u> (Town, county, and state)				10. Usual occupation <u>Printer</u>			
11. Industry or business <u>Herald & Mail Co.</u>				12. Name <u>Daniel J. Snyder</u>			
13. Birthplace <u>Franklin County Pa.</u>				14. Maiden name <u>Elizebeth McNamee</u>			
15. Birthplace <u>Franklin County Pa.</u>				16. Informant <u>William C. Snyder</u> Address <u>Hagerstown Md.</u>			
17. Burial (Burial, cremation, or removal. Which?) <u>Rest Haven Cemetery</u> Cemetery or crematory <u>Hagerstown Md.</u> Location				Date thereof..... <u>April 16, 1946</u> (month) (day) (year)			
18. Funeral director <u>Scott F. Minnich & Son</u> Address <u>Hagerstown Md.</u>				19. April 16 1946 (Date rec'd by registrar)			
20. DATE OF DEATH <u>April 13 1946</u> at <u>12:50p</u> AM				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 15 1946</u> to <u>April 13 1946</u> and that I last saw him alive on <u>April 13 1946</u>			
Immediate cause of death <u>Chronic Endocarditis</u> <u>refluxitis</u> <u>arterio sclerosis</u>				DURATION			
Due to				Due to			
Other conditions				(Include pregnancy within 3 months of death)			
Major findings of operations				Date of op.			
Autopsy results				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?				23. SIGNATURE <u>Wm. E. Miller</u> <u>Hagerstown Md.</u> Address..... Date signed <u>4/17/46</u>			

Registrar

RECEIVED

APR 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: *Washington*
 County *Hagerstown*
 City or town *Hagerstown*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *30 yrs.*
 Hospital, institution, or street address where death occurred
47 Robert Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Maryland* County *Washington*
 City or town *Hagerstown*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *47 Robert Street*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *Estella Stewart*

3. (b) Social Security Number
none

4. Sex *Female* 5. Color or race *Negro* 6. (a) Single, married, widowed, or divorced *Divorced*
 6. (b) Name of husband or wife *William Stewart*
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) *March 18, 1883*
 8. AGE: *63* Years *19* Months *19* Days *19* hrs. _____ min.

9. Birthplace *Harrisonburg, Va.*
 (Town, county, and state)
 10. Usual occupation *Domestic*

11. Industry or business *Edward Watson*
 12. Name *Harrisonburg, Va.*
 13. Birthplace *Nancy Adams*
 14. Maiden name *Harrisonburg, Va.*
 15. Birthplace *Perry Watson*

16. Informant *Pittsburg, Pa.*
 Address

17. Burial *4/19/46*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Rose Hill Cemetery*
 Location *Hagerstown, Md.*

18. Funeral director *Wm. H. Downey*
 Address *291 Frederick Street*

19. *April 9* 19*46*
 (Date rec'd by registrar) Registrar *Frank H. Brown*

MEDICAL CERTIFICATION

20. DATE OF DEATH *4/6* 19*46* at *10 P.* M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 1* 19*40* to *4/6* 19*46*
 and that I last saw him *4/6* alive on *4/6* 19*46*

Immediate cause of death *Cerebral Hemorrhage* DURATION *1 hour?*
arterio-sclerosis *21*

Due to *✓*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations *0* Date of op. *0*

Autopsy results *0*
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

Victor D. Miller
 23. SIGNATURE

DR. VICTOR D. MILLER. M. D. or other
 Address *131 W. WASHINGTON ST.* Date signed *4/8/46*

HAGERSTOWN, MD.

RECEIVED

APR 11 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04158 304

1. PLACE OF DEATH:

County WashingtonCity or town Rural - Little Orleans
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Little Orleans
(If outside city or town limits, write RURAL and give nearest town)Street No. West Sideling Hill
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Charles Russell Trail

3. (b) Social Security Number

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Emma E. Bell Trail7. Birth date of deceased (mo., day, yr.) Oct. 14, 18698. AGE: Years 76 Months 6 Days 1 If less than one day — hrs. — min. —9. Birthplace Piney Grove, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business —12. Name Nathan Trail13. Birthplace Piney Grove Md.14. Maiden name Fannie Stottlemeyer15. Birthplace Little Orleans, Md.18. Informant Robert L. TrailAddress 429 Kline Ave., E. Pittsburgh, Penna.17. Burial Date thereof April 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Piney Grove Meth. ChurchLocation Piney Grove, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 4/18/46 G. H. Veller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 15 1946 at 6 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19Immediate cause of death C. Pr. - myocarditis

DURATION

Due to Acute Ventricular fibrillationDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

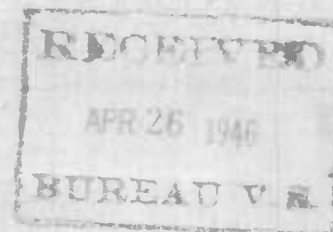
Accident, suicide, or homicide no Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature S. Robert WellsAddress Wash. Co., Md.23. SIGNATURE S. Robert WellsAddress Wash. Co., Md.Date signed 4/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178

CERTIFICATE OF DEATH

04159

Reg. Diat. No. 301

1. PLACE OF DEATH

County Washington
 City or town near St. James
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? locality 3 1/2 miles
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town St. James
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Severge David White

3. (b) Social Security Number

065-07-0243

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Dege Seville
 6.(c) If alive, give age 34 years
 7. Birth date of deceased (mo., day, yr.) Nov. 17 1909
 8. AGE: Years 36 Months 4 Days 24 If less than one day
 hrs. min.

9. Birthplace Berlin Penna.
 (Town, county, and state)

10. Usual occupation mechanic

11. Industry or business Mullen Ougars Works

12. Name David Clough White

13. Birthplace Pennsylvania

14. Maiden name Marie Beckman

15. Birthplace Berlin Penna.

16. Informant Mrs. David C. White

Address Rydia Md.

17. Buried Date thereof 4-13-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Berlin Pa.

Location Berlin Pa.

18. Funeral director Edith J. East

Address Williamstown Md.

April 11 1946 F. E. L. M. Elroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DURATION

multiple fractures

Due to 9 ribs - lower

skull fractures

Due to shock

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident April 10/46

Accident, suicide, or homicide..... Date of.....

Where did injury occur? St. James Wash. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) field

Means of injury airplane crash Injured at work?

Signature Robert W. Ellis Wash. Co. Md.

M. D. of power

Address Hagerstown Md. Date signed 4/10/46

RECEIVED

APR 13 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

133 East Washington Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 133 East Washington Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Catherine S. Zook

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife Jacob Zook

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 17, 18638. AGE: Years 83 Months 2 Days 5 It less than one day _____ hrs. _____ min.9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home12. Name Al Stump13. Birthplace Bridgeport, Maryland14. Maiden name Sheeley15. Birthplace Not Known16. Informant Mrs. Frances SpanglerAddress Hagerstown, Maryland17. Burial Date thereof 4-24-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. April 23 19 46 East Hagerstown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22 19 46 at 4:30 A.M.21. I CERTIFY that death occurred on the date above stated; that it attended deceased from 4/1 19 46 to 4/22 19 46and that I last saw him alive on 4/21 19 46Immediate cause of death Cerebral Hemorrhage DURATION 1 yearDue to arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller

DR. VICTOR D. MILLER M. D. or other

Address _____ Date signed 4/23/46

RECEIVED

APR 25 1946

BUREAU V.S.